Conclusion: SSR events are associated with a high burden of injury and occasionally fatality and expense to hospitals.Strict regulation regarding safety is essential as is improved safety provisions for spectators.

0702L: USE OF THE RISK ADJUSTED MORTALITY INDEX (RAMI): A VALID INDEX OF IN-HOSPITAL MORTALITY RISK IN SURGICAL PATIENTS?

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Aim: The NHS uses a number of indices to assess quality and safety. One measure is the RAMI, which adjusts risk for individual patient risk factors/co-morbidities. RAMI accuracy is highly dependent on quality of clinical coding and as a result its value has been questioned. Use of P-POSSUM prior to surgery is now commonplace and provides a prospective, physiological predictor of risk. We compared the correlation of RAMI with P-POSSUM scoring among surgical in-hospital mortalities.
Methods: We analysed 35 cases of post-operative, in-hospital mortality from both elective and emergency surgery during 2013. Variables assessed included age, gender, duration of admission and type of surgery, along with pre-operative P-POSSUM score and the RAMI score obtained following death.
Results: Median patient age was 71 (45–89) and 57% (n = 20) were female. Median in-hospital stay was 4 days (1–30) and 69% (n = 24) underwent emergency rather than elective surgery. Median P-POSSUM and RAMI scores were 30.3% (0.71–96.70%) and 25.3% (0.50–99.40%)respectively with correlated poorly ($\alpha = 0.04$, p = ns) for both elective and emergency surgery.
Conclusion: RAMI and P-POSSUM scores correlated poorly while there was a trend towards higher P-POSSUM scores within our cohort. The validity of RAMI remains in question and further large scale comparative work is indicated.

0736: DECISION-MAKING IN COMPLEX HAND FRACTURES AND THE USE OF CONE BEAM CT

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Aim: At our tertiary centre we have applied advanced imaging modalities for the management of proximal interphalangeal joint (PIPJ) fractures by using Cone Beam Computed Tomography (CBCT). As a result images can be compiled into a 3D volumetric format to aid surgical decision-making and management in these complex hand injuries.
Methods: The management of 27 patients who suffered with PIPJ fractures, all of whom had CBCT scans, in a 6-month period were analysed. We examined the radiographs; subsequent CBCT scans and decision making processes that went into their management.
Results: 85% of the patients reviewed, sustained their injury as a result of trauma. 63% of patients who went on to have CBCT scans for their PIPJ had a change in management as a result. Of these, 53% went on to have conservative management and avoided surgery. Following the use of CBCT, more than 50% of cases demonstrated more detailed and relevant information regarding the size and number of bony fragments involved in the fracture.
Conclusion: Plain x-rays are limited in evaluating articular involvement i.e. the number, size and location of bone fragments. We have found the use of CBCT to be extremely effective in surgical planning.

0746: ADHERENCE TO PRISMA CRITERIA IN SURGICAL LITERATURE IS SUB-OPTIMAL

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Aim: The PRISMA Statement (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) aims to optimise reporting of systematic reviews and meta-analyses via a 27-criteria checklist. We investigated if completeness of reporting in surgical studies has improved following its publication. We tested the relationship between PRISMA adherence and quality using AMSTAR (Assessing the Methodological Quality of Systematic Reviews) criteria.
Methods: Surgical systematic review or meta-analysis published in five high impact surgical journals between 2007–2011 were identified. Manuscripts were anonymised prior to assessment. Two blinded investigators independently scored manuscripts according to PRISMA and AMSTAR criteria, comparing studies published before (2007–2009) and after (2010–2011) publication of PRISMA. The relationship between PRISMA and AMSTAR scores was measured using Spearman's rank (r) test.
Results: Of 142 included manuscripts, 80 were published before and 62 after publication of PRISMA. Average reporting of the 27-critera set out by PRISMA was similar, before (70.4%) and after (74.1%;p = 0.239) its publication. Adherence to PRISMA significantly correlated with higher quality according to AMSTAR assessment ($r = 0.771$;$p < 0.001$).
Conclusion: Adherence to PRISMA in surgical systematic reviews remains sub-optimal. Authors should plan to ensure they can report in adherence with PRISMA, which will improve study quality. Journals should mandate PRISMA statement completion upon paper submission.

0784: ARE MOBILE PHONES "THE TICK" WITH THE INFECTIVE BITE: A MICROBIAL ANALYSIS OF MOBILE DEVICES WITHIN AN ACUTE SURGICAL UNIT

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Aim: Surging reliance of mobile technology has prompted disinfection guidelines nationwide. Nonetheless, no convincing evidence suggests mobile devices (MD) are a reservoir for pathogenic microorganisms. Our study evaluates the presence of microorganisms in MD use and whether frequency of disinfection influences this.
Methods: Prospective audit with Amies Charcoal Swabs obtained from all MD used within the unit over 24 hours. Swabs inoculated onto Blood-Columbia-Horse and CLED agars with Andrades indicator were incubated and examined for growth with Gram film and Staph Xtra latex kit up to 48 hours.
Results: 53 samples obtained (6 consultants, 20 trainees, 27 nurses). 42 reported 'never' cleaning MD over a week, while 11 reported between once to 21 times weekly.
Following incubation, 38/53 (72%) demonstrated no growth, while microorganisms were observed in 15/53 (28%). Of these 15 samples, 13 had <10 colony forming units(cfu), 1 with 10-20 cfu, 1 had > 20cfu.
All microorganisms were skin commensal flora. No correlation was seen between MD cleaning frequency and colonisation observed.
Conclusion: Despite a quarter of MD observed microorganism presence, frequency of disinfection has no influence on this. Translational infective potential of these commensal flora from MD into nosocomial infection remain unknown and further study is required.

0805: WHAT THEY DON'T TEACH IN MEDICAL SCHOOL: WHY PATIENTS DO AND DON'T CHOOSE A SURGEON

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Aim: Needing surgery is a stressful and scary time for a patient. It is no surprise, then, that patients shop around to find the right surgeon.
Methods: But what do they want? A survey was administered to a random cross-section of American adults to find out. Z-tests and Pearson's r correlations were analyzed.
Results: Among many other intriguing findings:
Prospective patients rated the importance of 24 factors on a 1 to 10 Likert-type scale. Eleven factors averaged above an 8 ($p < .0001$). Besides being board certified and experienced, patients strongly want a surgeon with whom they feel rapport. The data showed that one of the most powerful methods for creating rapport is for the surgeon to promise to "fight for" the patient to the patient's insurance company. Other critical factors involved trusted referral sources, competent staff, and being able to make appointments within a month.
The most trusted referrals come from primary care providers (selected by 30%) and family and friends (24%). If their primary care provider recommended a surgeon, patients were unlikely to choose a different surgeon ($p < .05$).